§ 9771 Applications for Certification.

(a) Any of the following entities may apply for certification as a health care organization:

~~(1) An entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (Knox-Keene Health Care Service Plan Act);~~

(~~2~~) (1) A disability insurer licensed by the Department of Insurance to transact health insurance or disability income insurance pursuant to Part 2 of Division 2 of the Insurance Code.

(~~3~~) (2) Any ~~entity authorized as a~~ workers compensation health care provider organization ~~by the Commissioner of Corporations pursuant to Part 3.2 of Division 4 of the Labor Code~~.

(b) An applicant must meet all of the requirements set forth in this article in order to be certified as a health care organization by the administrative director. Applicants must initially submit to the administrative director, as part of the application, a plan which will provide a clear and concise description of how occupational medical and health care services are to be provided and how each of the requirements in this article are met, and, where specified, in the manner required under each section. HCOs must include all documentation necessary to demonstrate that they meet the requirements for certification.

(c) Health care service plans ~~or workers compensation health care provider organizations~~ must provide written certification that at the time of application the applicant is not in violation of any provision of law or rules or orders of the ~~Commissioner of Corporations~~ Director of the Department of Managed Health Care, and that there are no outstanding orders, undertakings, or deficiency letters which involve the applicant. Disability insurers must provide written certification that at the time of application they are in good standing with the Department of Insurance. The requirement of this subdivision may be satisfied by verified statement under penalty of perjury by the president or managing officer of an applicant that the applicant meets the requirements of this subdivision, subject to verification by the administrative director.

(d) An applicant who is in compliance with requirements for certification by the ~~Department of Corporations or~~ the Department of Insurance may submit copies of any relevant exhibits, sections or other documents submitted as part of the primary certification application to meet any of the requirements of this article, provided that the applicant (1) verifies that ~~the Department of Corporations or~~ the Department of Insurance ~~have~~ has fully reviewed and approved the submitted information, (2) provides a concise narrative identifying any manner in which HCO services will be provided differently from those provided under the primary certification, and (3) provides a concise description for each requirement of this article, specifying how occupational medical and health care services or other services specifically and exclusively required by this article will be met.

(e) Applications must be in writing in the form and manner prescribed by the administrative director, and must be submitted on or after January 1, 1994. The original plus one copy of the application shall be submitted together with a fee as specified in subdivision (c). Each

application shall provide, in addition to the plan specified in subdivision ~~(f)~~(b), the following information:

(1) The names of all directors and officers of the health care organization.

(2) The title and name of the person designated to be the day-to-day administrator of the health care organization.

(3) The title and name of the person designated to be the administrator of the financial affairs of the health care organization.

(4) The name, medical specialty, if any, board certification, if any, and any unrestricted licenses (including states where licensed), of the medical director.

(5) The name, address, and telephone number of a person designated to serve as a liaison for the Division, who is responsible for receiving compliance and informational communications from the Division and for disseminating the same within the HCO organization.

(6) A sample of each type of contract with participating providers, claims administrators, and insurers, and any entities specifically providing services required by this article; and a list of contractors for each type of contract. Copies of contracts shall be made available to the administrative director upon request. The Division will maintain as confidential information pertaining to provider rates and other financial information in accordance with Government Code Section 6254(d)(1).

(7) An organizational chart demonstrating the structural relationships between the medical director, fiscal or financial administrator, and executive officers and administrators.

(8) The identity of any worker's compensation insurer that controls or is controlled by the applicant, as defined by Section 1215 of the Insurance Code.

(f) Each application for certification must be accompanied by a non refundable fee of $20,000~~, less any amount paid to the Department of Corporations which was required for authorization as a Workers' Compensation Health Care Provider Organization (WCHPO)~~.

(g) In lieu of an application for certification, an entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (a Knox-Keene Health Care Service Plan Act) and deemed to be an HCO pursuant to Labor Code Section 4600.5(c) shall submit to the administrative director:

(1) a concise description of how the health plan will satisfy the requirements of Labor Code Section 4600.5(c)(1 - 5) and Sections 9772 through 9778, inclusive,

of these regulations. At the time the materials required by this subsection are submitted to the administrative director for review, the health plan shall pay a nonrefundable documentation processing and review fee of $10,000; and,

(2) written certification that the health plan is not in violation of any provision of law or rules or orders of the Director of the Department of Managed Health Care, and that there are no outstanding orders, undertakings, or deficiency letters which involve the health plan. The requirement of this subdivision may be satisfied by verified statement under penalty of perjury by the president or managing officer of the health plan that the plan meets the requirements of this subdivision, subject to verification by the administrative director.

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600 and 4600.5, Labor Code.

§ 9771.2 Information to Be Furnished as it Becomes Available.

(a) If an HCO, or any person listed in section 9771(e)(8), is named as a defendant in a lawsuit that is materially related to the provision of medical treatment under Labor Code section 4600, the HCO shall inform the administrative director within 5 days of the day it becomes aware the suit is filed and shall provide a copy of the complaint.

(b)(1) If ~~an applicant or~~ a certified HCO is a health care services plan and if the ~~Commissioner of Corporations~~ Director of the Department of Managed Health Care begins proceedings against the plan under Articles 7 or 8 of the Knox-Keene Health Care Service Plan Act of 1975, the ~~applicant or~~ certified HCO shall inform the administrative director within 5 days of the day it becomes aware of the proceedings. The requirements of this subdivision shall also apply to an HMO deemed an HCO pursuant to Labor Code Section 4600.5(c) while the administrative director is reviewing the documentation required by Section 9771 subdivisions (g) (1) and (2) prior to issuing the HMO its certification.

(2) If an applicant or a certified HCO is a disability insurer and if the Commissioner of Insurance begins proceedings against the insurer under Insurance Code section 704 or an examination under section 730, the applicant or certified HCO shall inform the administrative director within 5 days of the day it becomes aware of the proceedings or examination.

~~(3) If an applicant or a certified HCO is a workers' compensation health care provider organization and if the Commission of Corporations begins proceedings against the organization under Chapters 7 or 8 of the Workers' Compensation Health Care Provider Organization Act, the applicant or certified HCO shall inform the administrative director within 5 days of the day it becomes aware of the proceedings.~~

(c) A change in the information required by Section 9771(e) (1), (2), (3), (4), (5), and (8) shall be submitted within 5 days of the change.

(d) If an applicant or an affiliate of an applicant enters a contract whereby the applicant is to be purchased by or otherwise come under the control of another entity, the applicant shall notify the administrative director within 5 days of entry into the contract.

Authority: Sections 133, 4600.5, 5307.3, Labor Code.
Reference: Sections 4600.3, 4600.5, Labor Code.

§ 9771.66 Deceptive Advertising.

Without limitation upon the meaning of Section 4600.6 of the Code, an advertisement or other consumer information is untrue, misleading or deceptive if:

(a) It represents that payment is provided in full for the charge for workers' compensation health care other than in accordance with what is required under the Labor Code.

(b) It represents that payment is provided for the customary charges for workers' compensation health care other than in accordance with what is required under the Labor Code.

(c) It represents that the organization, firm or solicitor or any provider or other person associated therewith is licensed or regulated by the Department of ~~Corporations~~ Managed Health Care or Administrative Director or other governmental agency, unless such statement is required by law or regulation or unless such statement is accompanied by a satisfactory statement which counters any inference that such licensing or regulation is an assurance of financial soundness or the quality or extent of workers' compensation health care.

Authority cited: Stats. 1997, Ch. 346, Section 5.-
Reference: Sections 4600.3, 4500.5 and 4600.6, Labor Code.

§ 9772 General Standards.

(a) HCOs must demonstrate that they meet the following requirements:

(1) All facilities located in this state including, but not limited to, clinics, hospitals, laboratories, and skilled nursing facilities to be utilized by the HCO for the delivery of occupational medical and health care services or other services specifically required by this article shall be licensed by the State Department of Health Services, if such licensure is required by law, and shall meet any other relevant certification requirements. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(2) All personnel employed by or under contract to the HCO shall be licensed or certified by their respective board or agency, where such licensure or certification is required by law.

(3) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for such equipment shall be licensed or certified as required by law.

(4) The HCO shall provide continuity of care and timely referral of patients to other providers in a manner consistent with professionally recognized standards of care.

(5) All services shall be available and accessible at reasonable times to all HCO enrollees.

(6) The HCO may employ and utilize allied health personnel for the furnishing of occupational health services to the extent permitted by law and provided such use is consistent with professionally recognized standards of care; however, any course of treatment beyond first aid, as defined in subdivision (c) of Section 14311, shall provide for at least one face to face visit with a primary treating physician.

(7) The HCO shall have the organizational, financial, and administrative capacity to provide services to employers, claims administrators, and HCO enrollees. The HCO shall be able to demonstrate to the Division that medical decisions are rendered by qualified providers unhindered by fiscal and administrative management, and that such decisions adhere to professionally recognized standards of care.

Any applicant that is owned in whole or in part or controlled by a workers' compensation insurer or self-insured employer shall, in addition to the requirements set forth above, further demonstrate that the organization's claims function shall have no influence or control over medical decision-making. The applicant shall further demonstrate that the clear authority of its Medical Director over all medical decisions is reflected both in its organizational chart and any internal procedure manual or other internal description of HCO operations.

(8) All contracts with claims administrators, employers, providers and other persons or entities furnishing services specifically required by this article shall be consistent with the requirements of this article and Division 4 of the Labor Code.

Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code.
Reference: Section 4600.5, Labor Code.

§ 9779 Certification.

(a) Once an applicant has completed an application and submitted a fee in accordance with Section 9771 and has demonstrated to the administrative director that its organization has met all of the criteria for certification, the administrative director will certify the organization as an HCO for a period of three years, unless earlier revoked or suspended.

(b) Once the Administrative Director has determined that an entity licensed as a full service health care service plan under Section 1353 of the Health and Safety Code (a Knox-Keene Health Care Service Plan Act) and deemed to be an HCO pursuant to Labor Code Section 4600.5(c) has

complied with the requirements of Section 9771 subsections (g) (1) and (2) the administrative director shall certify the organization as an HCO, pursuant to Section 4600.5(c), for a period of three years unless earlier revoked or suspended.

~~(b)~~(c) A certification shall state that a particular entity is certified as a health care organization to provide health care to injured employees for injuries and diseases and other services in accordance with the terms of the entity's application. The certification shall also state: (1) the geographic service area in which the health care organization is permitted to provide health care, (2) the maximum number of enrollees, (3) the name or names under which the health care organization is permitted to provide health care, (4) the date of expiration of the certification, and (5) any other conditions or limitations.

~~(c)~~(d) The HCO will be recertified at the expiration of each subsequent three year period, provided it continues to meet the requirements of this article and timely pays a recertification fee of $10,000.

~~(d) Applicants that have received provisional certification under prior regulations may obtain full certification upon payment of the balance of the full application fee required pursuant to this section.~~

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600, 4600.5 and 4600.7, Labor Code.

§ 9779.1 On-Site Surveys.

(a) The HCO must ensure that it will be available for and cooperate with on-site surveys as the administrative director deems necessary to insure compliance with this article, including during the initial certification process. The administrative director will coordinate on-site surveys with the Department of ~~Corporations~~ Managed Health Care to the extent feasible.

(b) The administrative director will notify the HCO of deficiencies found by the survey team. The administrative director will provide the HCO a reasonable time to correct the deficiencies. Failure on the part of the HCO to timely correct noted deficiencies may result in suspension or revocation of an HCO's certification in accordance with Section 9779.2.

(c) Reports of all surveys shall be open to public inspection, except that no survey shall be made public unless the HCO has had an opportunity to review the survey and file a statement in response within 30 days, to be attached to the report. Deficiencies shall not be made public if they are corrected within 30 days of the date that the HCO was notified.

(d) Non-routine audits will be charged based on the actual cost for performing the audit. The amount shall include the actual salaries or compensation paid to the persons making the audit, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the Administrative Director. Overhead costs shall be based on the total expenditure for operating

expenses and equipment, except travel, of the managed care unit of the Division of Workers' Compensation for the previous fiscal year. The invoice will be sent upon the completion of the audit and shall be paid within 30 calendar days.

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600, 4600.5 and 4600.7, Labor Code.

§ 9779.3 Obligations of employer covered by ~~contracts~~ a contract with a health care ~~organizations~~ organization.

(a) When an insurer or employers, a group of self-insured employers, or self-insured employers have contracted with ~~at least two~~ a health care ~~organizations~~ organization certified pursuant to Section 4600.5 of the Labor Code the employer shall provide information to all employees who are eligible to be enrolled in the health care ~~organizations~~ organization as follows:

(1) a new employee shall be provided with the choice of enrolling in an HCO or designating the employee's own personal physician or personal chiropractor no later than 30 days following the employee's date of hire.

(2) a current employee shall be provided with the choice of enrolling in an HCO or designating the employee's own personal physician or personal chiropractor no later than 30 days before the initial enrollment period ends;

(3) an employer must provide information concerning the ~~choice of HCOs available~~ HCO it is offering to its employees no later than 30 days prior to the final date for enrollment. Information shall be provided in written form, in no less than twelve (12) point typeface, and in a language understandable to employees. The information provided must include, at a minimum, the following:

(i) the ~~names of each~~ name of the HCO offered;

(ii) the corporate or business name of all entities which own or control ~~each~~ the HCO offered; and indication of relationship, if any, of the HCO to workers' compensation carrier or self-insured employer;

(iii) the services offered by ~~each~~ the HCO;

(iv) a complete listing of all primary treating physicians, specialist physicians, and clinics participating in ~~each~~ the HCO who would be reasonably accessible to the employee for the provision of occupational health services. Primary treating physicians who are not accepting new patients must be clearly identified;

(v) If the HCO is also the provider of group health coverage for non-occupational health services, the HCO policy regarding enrollees' ability to use their personal

physician (for non-occupational health services) for treatment of work injuries;

(vi) any provider risk-sharing arrangements related to utilization of services.

~~(4) If one or more of the HCOs offered by the employer is owned or controlled by the same individual or by the same corporate or business entity, the information provided pursuant to (a)(3) shall explain the nature of any material and significant differences between the HCOs in a manner that would allow the employee to make an informed choice between HCOs. For purposes of this section, the term "control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an entity; control shall be presumed to exist if any individual or entity, directly or indirectly, owns, controls, holds with power to vote, or hold proxies representing, more than 10% of the voting power.~~

~~(5)~~ (4) Within fifteen days following enrollment, the HCO must provide to each enrollee complete information regarding HCO services and processes, including but not limited to:

(i) the services offered, including interpreters services, how such services are obtained, hours of services;

(ii) the definition of emergency care, how to obtain out-of-service treatment, how to obtain after-hours services;

(iii) case management and medical management processes, selection of the primary treating physician, and method for obtaining second opinions, change of physician, or referrals to chiropractors, physical therapists, or specialists;

(iv) the grievance and dispute resolution procedures;

(v) additional services offered, including return to work, health and safety, patient assistance, and patient education.

(b) Employees shall designate their enrollment option on form DWC 1194. This form must be maintained in the employee's personnel file for a minimum of three (3) years, and be made available to the employee or employee's representative on request.

Employees who designate on form DWC 1194 that they do not wish to enroll in an HCO and wish to pre-designate their own personal physician or chiropractor shall ~~be given a form for such pre-designation by the employer within 3 working days of receipt by employer of~~ pre-designate that physician or chiropractor on the form 1194. At least once each year the employer shall provide the employee with a notice informing the employee of his or her right to continue as an enrollee of ~~an~~ the HCO, change to another HCO if another HCO is offered by the employer, or designate the employee's own physician instead of ~~an~~ the HCO. If another HCO is offered by the employer and the employee chooses to change to another HCO or if the employee chooses to designate a personal physician, the employee shall designate such choice on a form DWC 1194, which shall be provided by the employer.

~~(c) For an employee enrolled in an HCO pursuant to paragraph (3) of subdivision (c) of Section 4600.3 of the Labor Code, the employee's personal physician or chiropractor for non-occupational care must be available to the employee within an HCO offered by the employer for the treatment of work injuries or illnesses.~~

Authority cited: Sections 133, 4600.3, 4600.5, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600, 4600.3 and 4600.5, Labor Code.

§ 9779.4 – DWC Form 1194.

[Form 1194 attached]

Authority cited: Sections 133, 4600.5, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600 and 4600.5, Labor Code.

§ 9779.45 Minimum Periods of Enrollment.

Pursuant to Labor Code Section 4600.3:

(a) An employee whose employer does not offer non-occupational health coverage under a plan established pursuant to collective bargaining, and does not offer to pay more than one-half the cost of non-occupational health coverage for that employee under another plan, may be treated for occupational injuries and illnesses by a physician of the employee's choosing after 90 days from the date the injury was reported.

(b) An employee whose employer offers non-occupational health coverage under a plan established pursuant to collective bargaining, or offers to pay more than one-half the cost of non-occupational health coverage for that employee under another plan, may be treated for occupational injuries and illnesses by a physician of the employee's choosing after 180 days from the date the injury was reported or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.

~~(c) An employee whose employer offers non-occupational health coverage under a plan established pursuant to collective bargaining, or offers to pay more than one-half the cost of non-occupational health coverage for that employee under another plan, and whose physician for non-occupational illnesses or injuries is participating in at least one of the health care organizations offered to the employee, may be treated for occupational injuries and illnesses by a physician of the employee's choosing after 365 days from the date the injury was reported or upon the date of contract renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.~~

Authority cited: Sections 133, 4600.3, 4600.5, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600, 4600.3 and 4600.5, Labor Code.

§ 9779.5 Reimbursement of Costs to the Administrative Director; Obligation to Pay

Share of Administrative Expense.

(a) Each organization certified under this article shall pay to the administrative director an amount as estimated by the administrative director for the ensuing fiscal year, as a reimbursement of a share of all costs and expenses, including routine on-site surveys, data collection and dissemination and overhead, reasonably incurred in the administration of this article and not otherwise recovered by the administrative director under this article or from the Worker's Compensation Managed Care Fund. The amount shall be assessed annually on or before April 15 and ~~may~~ shall be paid to the Workers' Compensation Managed Care Fund ~~in two equal installments. The first installment shall be paid~~ on or before July 1 of each year ~~and the second installment shall be paid on or before December 15 of each year~~.

(1) Annual Assessment: The assessment shall be calculated on the basis of the number of enrollees in each individual HCO. Each HCO will be assessed a sum equivalent to $1.00 per enrollee, based on the number of enrollees enrolled in the HCO on December 31 of the prior calendar year.

(2) Loan Repayment Surcharge: Each HCO will be assessed an annual surcharge of fifty cents per enrollee, based on the number of enrollees in the HCO on December 31 of the prior calendar year, until the loan is fully repaid. This surcharge will be used solely to reimburse the general fund for the loan made to the Workers' Compensation Managed Care Fund. The surcharge shall be assessed at this level for up to five years, commencing with the 1999 assessment. If the general fund loan has not been fully repaid after five years, the annual surcharge for each HCO shall be adjusted the following three years to fully repay the loan as follows:

> 2004: (One-third of outstanding loan balance) divided by (total number of enrollees in all certified HCOs) times (number of enrollees in HCO)
>
> 2005: (One-half of outstanding loan balance) divided by (total number of enrollees in all certified HCOs) times (number of enrollees in HCO)
>
> 2006: (Total outstanding loan balance) divided by (total number of enrollees in all certified HCOs) times (number of enrollees in HCO)

(b) Non-routine audits conducted in response to complaints will be charged based on the actual cost for performing the audit. The invoice will be sent within sixty days of the completion of the audit and shall be paid within 30 calendar days after the billing date.

(c) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this article.

Authority cited: Sections 133, 4600.5, 4600.7, 4603.5 and 5307.3, Labor Code.
Reference: Sections 4600 and 4600.5, Labor Code.